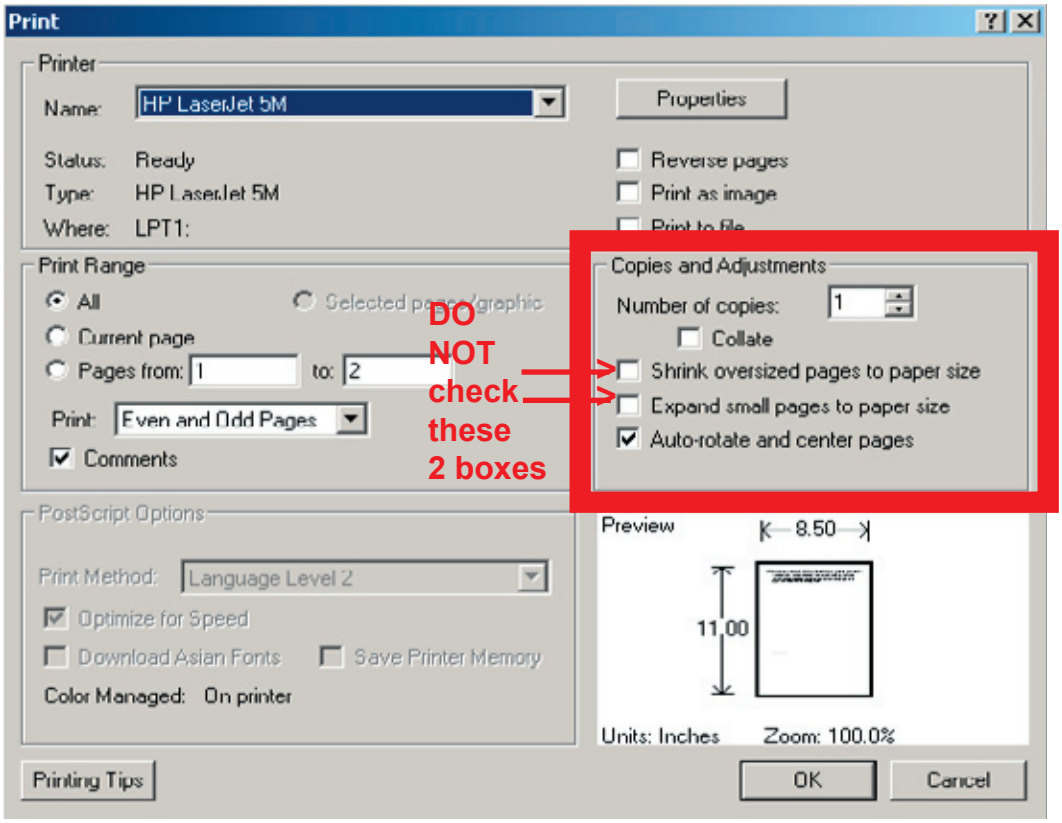
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Dietitian/Nutritionist License Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Dietitian/Nutritionist

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 687-007 (Rev 2/2006)

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Washington State Department of Health
Dietitian/Nutritionist Program
PO Box 1099
Olympia, WA 98507-1099

Dietitian / Nutritionist Application Instructions

1. **Demographic Information**—Complete in full.
2. **Previous Credentials**—List all previous or current jurisdictions in which you hold a credential.
3. **Professional Training and Experience**—List in chronological order all professional education and experience including college or university, technical or professional school and practice pertaining to dietitian or nutritionist.
4. **Personal Data Questions—**Answer all questions and attach supporting documents where applicable. Be advised that any statement you make may be used in an adjudicative proceeding, if such proceeding were to be conducted under the Uniform Disciplinary Act (UDA) and that you may consult with an attorney at your own expense prior to making a statement or providing additional documentation.
5. **AIDS Education and Training Attestation—**Sign and date the attestation if you have competed the required training. Certified Dietitians are required to have 4 hours of training; Certified Nutritionists are required to have 4 hours of training.
6. **Applicant's Attestation—**Read carefully. Sign and date the attestation.

Certified Dietitian—Individuals applying for certification as a dietitian must submit:

1. A completed application and the $75.00 fee. (Make the check or money order payable to the "Department of Health".)
2. Send a photocopy of your current registration card from the Commission on Dietetic Registration (CDR),

   or

   a letter from the CDR attesting to you having passed the test leading to registration, being currently registered, or having met the criteria for registration on June 9, 1988.

   or

   Individuals applying for certification as a certified dietitian who have not passed the required written examination or who are not registered with the CDR must:

1. Submit a completed application and the $75.00 fee. (Make the check or money order payable to the "Department of Health.")
2. Have official transcripts forwarded directly from the issuing college or university showing completion of a baccalaureate degree or higher in a major course of study in human nutrition, foods and nutrition, dietetics, or food management.
3. Take and pass the required written examination.
4. Provide verification of **4 hours** of AIDS education and training.

Certified Nutritionist—Individuals applying for certification as a nutritionist must submit:

1. A completed application and the $75.00 fee. (Make the check or money order payable to the “Department of Health”.)
2. Meet the qualifications outlined above for certified dietitian, **or** have official transcripts forwarded directly from the issuing college or university showing completion of a masters or doctorate degree in one of the following subject areas: human nutrition, nutrition education, foods and nutrition, or public health nutrition. The college or university is to be accredited by the Western Association of Schools and Colleges or by a national or regional body recognized by the Higher Education Coordinating Board at the time the applicant completed the required education.

Send Application and Fee To:

Department of Health
Dietitian/Nutritionist Program
PO Box 1099
Olympia, WA 98507-1099

If you have any questions, you may call our Customer Service Center at (360) 236-4700 during normal business hours.

Renewal of Registration

When you receive your license, you need to check the expiration date. The license will expire on your first birthdate. A courtesy renewal notice will be sent about 45 to 60 days prior to the expiration date. However, it is the responsibility of the certified professional to maintain current status with the Department of Health.

Please keep this office advised **in writing** of any name and/or address changes.

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only

☐ Application ☐ Transcripts ☐ Aids
☐ Fee ☐ CDR Card

LICENSE #

Application For Certified Dietitian or Nutritionist

Applying for: ☐ **Dietitian** ☐ **Nutritionist**

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. **All fees are non-refundable.**

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)
( )

SOCIAL SECURITY NUMBER (**Required** under 42 USC 666 and Chapter 26.23 RCW)
— —

Gender	Birthdate (MO/DA/YR)	PLACE OF BIRTH (City/State)
☐ Female ☐ Male	/ /	

Have you ever applied for a Washington license before? ☐ Yes ☐ No

If yes, list date(s):

Have you ever been known by any other name? ☐ Yes ☐ No

If yes, list.

2. Previous Credentials

List all states and/or jurisdictions in which you have any healthcare practitioner license. Please list all active, inactive, and expired licenses. Please list license type. Request the state and/or jurisdiction send official verification directly to this office.

☐ I have never been licensed, certified or registered in any state or local jurisdiction.

STATE/JURISDICTION	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSED BY		EXPIRATION DATE
		ISSUE DATE	NUMBER		EXAM	OTHER	

3. Professional Training and Experience

List in chronological order all professional education and experience including college or university, technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation to present whether or not engaged in activities related to dietitian or general nutrition.

NAME & LOCATION OF INSTITUTION, PLACE OF PRACTICE OR OTHER	DEGREE/CERTIFICATE OR NATURE OF EXPERIENCE OR SPECIALTY	DATE RECEIVED		BEGINNING DATE	ENDING DATE

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Aids Education and Training Attestation

I certify I have completed the minimum of ☐ 4 hours (for dietitian) ☐ 4 hours (for nutritionist) of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population consideration. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my credential may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date

6. Applicant's Attestation

I, _____ , certify that I am the person described and
NAME OF APPLICANT

identified in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____

Signature of Applicant Date

Official Use Only
Washington State Records Center